Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SADI Pain Management 2525 W. Bellfort St. Ste. 120 Houston, TX 77054 - 5024	MFDR Tracking #: M4-05-9168-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Liberty Insurance Corp. Rep Box: 28	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary; taken from the Table of Disputed services: "Not paid fair/unreasonable, paid fair/reasonable."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - *$520.00
3. CMS 1500(s)
4. EOB's

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No response received.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
03/01/05	X815 / X815	72020-TC ($14.76 x 125%)	1-5	$18.45
03/01/05	B377/ B377	72275–TC-59($78.97 x 125%)	1-5	$98.71
Total Due:				$117.16

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

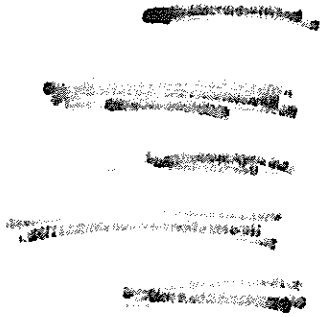
* The Requestor submitted an e-mail dated 05/08/07 withdrawing 99499.

1. This dispute relates to procedures/services that were billed under procedure code 72020-TC and 72275–TC-59 for DOS 03/01/05.

2. Per review of Box 32 on CMS-1500 the service was performed in Bexar County, zip code 78240. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

3. These services were initially denied by the Respondent with denial reasons:

- X815 – "This procedure is incidental to the primary procedure, and does not warrant separate reimbursement."
- B377 – "This is a bundled procedure; no separate payment allowed."



4. These services were denied after reconsideration by the Respondent with denial reason:

- X815 – "This procedure is incidental to the primary procedure, and does not warrant separate reimbursement."
- B377 – "This is a bundled procedure; no separate payment allowed."

5. Per Rule 134.202(b), CPT code 72020 and 72275 are not bundled to any other code billed on the same day; therefore, according to Rule 134.202(c) (1) reimbursement of $117.16 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $117.16 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER :

[redacted] 02/11/08

Authorized Signature | Medical Fee Dispute Resolution Officer | Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.